UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

VIVITROL(naltrexone)

Patient name: _____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Physician NPI:_____

Phone#:_____Ext. and options_____Fax#_____

Dose_____

All information to be legible, complete and correct or form will be returned

_____

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO (801) 536-0477

CRITERIA:

- Diagnosis of alcohol abuse.
- Negative urine screen for opioids or passed naloxone challenge.
- Description of the psychosocial support to be received by patient, as indicated by chart notes or a brief letter of medical necessity.
- Negative screen for liver problems.

INFORMATION:

To be given in clinic setting only. Patients with HMO's (except IHC) will have to make arrangements with their HMO for coverage. Provider will bill with J-code 2315, NDC number, and PA number.

AUTHORIZATION:

Initial authorization is for 6 months.

RE-AUTHORIZATION:

Updated letter of medical necessity.